

Haggerty Neighborhood Council & Community School

# Strawberry Hill Camp



*Summer Camp 2013*

REGISTRATION BEGINS  
MARCH 20 THROUGH JUNE 14, 2013

*\*PLEASE COMPLETE THE SHC REGISTRATION PACKET & MAIL IT TO:*

HAGGERTY COMMUNITY SCHOOL  
ATTENTION OF AMANDA KIERCE  
110 CUSHING STREET  
CAMBRIDGE, MA 02138

*This camp must comply with regulations of the Massachusetts  
Department of Public Health and be licensed by the Cambridge Board  
of Health*

**Haggerty Community School/Strawberry Hill Camp\* Registration Form \* Summer 2013**

110 Cushing Street \* Cambridge, MA 02138 \* Office Phone: 617.349.6264 Fax: 617.349.6034

**Camper Information:** (Please use a separate form for each child)

Child's Name	Female	Male
Address:		
City:	Zip Code:	
Home Phone:	Birthday:	Age:
Grade entering in September 2013:		School Attending:

*Ethnicity Please identify my child as:*

African American	Caucasian	Asian	Haitian	Hispanic	Other
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**Parent/Guardian Information**

Parent/Guardian's Name:	
Home Number:	Office/Cell Number:
Email address:	
Parent/Guardian's Name	
Home Number:	Office/Cell Number:
Email address:	

**Emergency Contacts**

Name 1:	Relationship:
Address:	
Home Phone:	Cell Phone:
Name 2:	Relationship:
Home Phone:	Cell Phone:

**Release & Signatures**

I hereby give permission for my child to participate in all Strawberry Hill Camp activities and trips.	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
I give my permission to the City of Cambridge/Community Schools to use photographic and video images of my child and family for publicity purposes. I acknowledge that publicity could include the use of our names and images in any slide shows, websites, social media, or articles submitted for publication or distribution.	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
As far as I am aware my child is NOT allergic to any types of sunscreens and I give permission for the staff to reapply.	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
I hereby give permission for authorized staff to take my child to the nearest hospital for emergency treatment. If a parent or guardian cannot be reached, hospital personnel may proceed with emergency treatment for my child.	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>

The individuals listed below may pick up my child from camp. If someone other than the people listed below, I will notify camp staff in advance.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**I am registering my child for the following weeks**

- ☐ **Session 1A:** June 24-June 28 \$160 ☐ **Session 1B:** July 1-July 5 \$160 \*No Camp on July 4<sup>th</sup>
- ☐ **Session 2A:** July 8-July 12 \$160 ☐ **Session 2B:** July 15-July 19 \$160
- ☐ **Session 3A:** July 22-July 26 \$160 ☐ **Session 3B:** July 29-August 2 \$160
- ☐ **Session 4A:** August 5-August 9 \$160 ☐ **Session 4B:** August 12-August 16 \$160

Please register my child for the extended day program from 3:30-5:30pm \$30/wk ☐ Yes ☐ NoPlease register my child for the early drop off program from 7:30-8:00am \$20/wk ☐ Yes ☐ No**Office Use Only:**Registration Fee \$25.00 ☐Tuition Amount \_\_\_\_\_ ☐**DEPOSIT(\$25/wk)** \_\_\_\_\_ ☐**Voucher** \_\_\_\_\_ ☐**Scholarship** \_\_\_\_\_ ( % granted)

Total Amount Due \_\_\_\_\_

☐ Health Form☐ Information Release☐ Financial Assistance Form (if applicable)☐ Application for Enrollment☐ Emergency Cards (2 pink)☐ Medical Release Form (if applicable)

Department of Human Service Programs  
Community School

**Health Form**

**This form must be completed and signed by a physician and returned before the first day of camp. Information is confidential.**

Name of child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian 1: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**Health care coverage:**

Harvard Vanguard \_\_\_\_\_ ID number: \_\_\_\_\_

Blue Cross Blue Shield \_\_\_\_\_ ID number: \_\_\_\_\_

Medicaid \_\_\_\_\_ ID number: \_\_\_\_\_

Other plan (name) \_\_\_\_\_ ID number: \_\_\_\_\_

Does your child have any allergies, i.e. hay fever, insect bites, food reactions? Yes \_\_\_\_ No \_\_\_\_  
If yes, please describe \_\_\_\_\_

\_\_\_\_\_

Does your child have an Epi-Pen for anaphylactic shock? Yes \_\_\_\_ No \_\_\_\_

Does your child have any special dietary restrictions? If yes, please describe

\_\_\_\_\_

Is your child presently being seen by a physician, staff at a guidance facility or any other health care professional? If yes, by whom and for what reason?

\_\_\_\_\_

Does your child have any unusual fears or special needs we should be aware of?

\_\_\_\_\_

# Immunization Record To be completed by physician

**\*Please Note:** Camps are not staffed with licensed nurses.

Please indicate dates for the following immunizations for \_\_\_\_\_(Name)\_\_\_\_(DOB)

DTaP/DTP/DT/Td #1\_\_\_\_\_ #2\_\_\_\_\_ #3\_\_\_\_\_ #4\_\_\_\_\_ #5\_\_\_\_\_

Td/Tdap Boosters #1\_\_\_\_\_

Polio IPV/OPV #1\_\_\_\_\_ #2\_\_\_\_\_ #3\_\_\_\_\_ #4\_\_\_\_\_

Hepatitis B #1\_\_\_\_\_ #2\_\_\_\_\_ #3\_\_\_\_\_

MMR #1\_\_\_\_\_ #2\_\_\_\_\_

Varicella # 1\_\_\_\_\_

Other: #1\_\_\_\_\_

Describe any physical conditions or impairments requiring restrictions in camp activities and indicate specific treatments if needed..

\_\_\_\_\_

Please provide the name of any medication that is **required** to be taken during camp time.

\_\_\_\_\_

\_\_\_\_\_

I hereby certify that \_\_\_\_\_ (name of child) has been examined on \_\_\_\_\_ (date), and that he/she is in good physical condition and is capable of participating in all camp activities.

\_\_\_\_\_  
Physician's signature

date

\_\_\_\_\_  
Physicians' name (Printed)

\_\_\_\_\_  
Facility name

\_\_\_\_\_  
Address

Phone #

I hereby give permission for authorized staff to take my child to the nearest hospital for emergency treatment.

\_\_\_\_\_  
Parent/Guardian's signature

\_\_\_\_\_  
date

This form must be completed & returned to the  
**Haggerty Neighborhood Council & Community School**  
at 110 Cushing Street\*Cambridge, MA 02138 before your child may attend camp.

## ~ Financial Assistance Form (OPTIONAL)

Department of Human Services ~ Neighborhood Council &amp; Community Schools Division

We ask everyone who possibly can, to pay the full amount so that we can continue to offer financial aid to those who need it most. All information is kept strictly confidential.

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent/Guardian #1: \_\_\_\_\_ Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parent/Guardian #2: \_\_\_\_\_ Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Please list **everyone** living in the home (primary residence), including parent(s):

1. \_\_\_\_\_ Age: \_\_\_\_\_
2. \_\_\_\_\_ Age: \_\_\_\_\_
3. \_\_\_\_\_ Age: \_\_\_\_\_
4. \_\_\_\_\_ Age: \_\_\_\_\_
5. \_\_\_\_\_ Age: \_\_\_\_\_
6. \_\_\_\_\_ Age: \_\_\_\_\_

You may be asked for documentation of the answers below. Please be sure to include all sources of income to your household.

	Weekly	<u>OR</u>	Monthly
Child Support			
Alimony			
Gross Pay, Wage Earner #1			
Gross Pay, Wage Earner #2			
Gross Pay, Wage Earner #3			
Unemployment Benefits			
AFDC			
Rental Income			
Other Income			
Total Income			

Are there any special financial issues you would like us to take into consideration?

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To the best of my knowledge, the above information is correct.

\_\_\_\_\_  
Parent/Guardian Signature\_\_\_\_\_  
Date

For Office Use Only:

Award Determined \$ \_\_\_\_\_ Denied \_\_\_\_\_ Date Determined: \_\_\_\_\_

We require official documentation along with our financial aid form, in order to be able to process your scholarship award. You must include your most recent tax return either 2012/2011. Please have this information to the director, Amanda Kierce, no later than Friday May 17, 2013 in order to receive your potential scholarship award. We want to ensure that we are being fair to all children so thank you for your cooperation.

Sincerely,

The Haggerty Community School

**DHSP Application for Enrollment**  
**Haggerty Community School/Strawberry Hill Camp**

The Department of Human Services is committed to work jointly with families to gain a greater understanding of the interests and needs of each individual child. Good communication between families and the Department of Human Services staff will help us better serve your child. We appreciate your willingness to work jointly with us to support the learning and well being of your child. The following information will assist us greatly. Any additional information regarding your child's specific needs is greatly appreciated.

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Child's Last Name	First Name	Nickname
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School Attending	Grade	Date of Birth
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Parent/Guardian Name (1)

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Home Address

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Home Phone Number	Cell Phone Number
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Work Place	Work Phone Number
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Email Address

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Parent/Guardian Name (2)

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Home Address

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Home Phone Number	Cell Phone Number
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Work Place	Work Phone Number
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What language do you speak at home? \_\_\_\_\_

Have there been any major changes in your family routine during the past year? A new baby? Moving? Accident or injury to your child or other family member?

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How does your child usually respond to a new experience? Shy? Assertive? Please Describe.

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What do you find most effective in calming your child when he/she is upset?

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What activities do your child like best? Favorite toys/games/songs/activities

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Does your child need individual attention for certain activities? Yes \_\_\_\_ No \_\_\_\_  
If yes, in what activities does your child need special attention or assistance?

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What additional aspects of your child's physical and/or emotional development would you like our staff to know about?

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Additional Comments:

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Parent's Signature

Date

**City of Cambridge**  
**Department of Human Service Programs**  
**Information Release Form**

\_\_\_\_\_  
(PRINT Child's Name)

\_\_\_\_\_  
(Name of School)

**Please circle one:**      **NEW STUDENT**

**RETURNING STUDENT**

I am applying for: (Please circle your program choice.)

**Youth Centers**

Area IV Pre-teen  
Area IV Teen  
Frisoli Pre-teen  
Frisoli Teen  
Gately Pre-teen  
Gately Teen  
Moore Teen  
West Cambridge Pre-teen  
West Cambridge Teen  
MSP @ Frisoli  
MSP @ Gately

**Community  
Schools (CS)**

Cambridgeport CS  
Fitzgerald CS  
Fletcher Maynard CS  
**Haggerty CS**  
Harrington CS  
Kennedy CS  
King CS  
Linnaean CS  
Morse CS  
Tobin CS

**Afterschool Childcare**

Fletcher Maynard K-3  
King K-2 Room 1  
King K-2 Room 2  
Morse K-2  
Morse 3-5  
Peabody K-2  
Peabody 2-5

**King Open  
Extended Day  
(KOED)**

**Preschool Childcare**

East Cambridge  
Haggerty  
King Open  
M. L. King  
Morse  
Peabody

**Recreation**

Camp Rainbow  
Saturday Program  
Evening Program

(MSP=Middle  
School Partnership)

I hereby authorize the Department of Human Services (DHSP) to observe my child in his/her school day classroom or program and to discuss my child's educational, physical, medical, psychological and/or other needs with his/her teachers, specialists, therapists, medical providers and other caregivers for the purpose of evaluating his/her participation in DHSP's out of school time (OST) and preschool programs.

**Parent/Guardian Name (Please Print):** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**PERMISSION TO OBTAIN STUDENT RECORDS**  
**(IEP, 504 Plan, behavior plans)**

I hereby authorize my child's school/program to release my child's records including his/her Individualized Education Program (IEP), Behavioral Intervention Plan and/or Section 504 Plan. DHSP will not disclose the content of any such records to any other party without my written consent, except as DHSP may be required by law to do so. All records will be used for the purpose of evaluating my child's participation in DHSP's out of school time (OST) programs.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Revised 1/2012